

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-004073

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

365

STATE FILE NUMBER

FILED JAN 22 1963

1. PLACE OF DEATH

a. COUNTY

St. Louis Missouri

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN

Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Missouri COUNTY

c. CITY
OR
TOWN

ST. Louis

Inside Limits

Yes ☐ No ☐c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR
INSTITUTION

Homer G. Phillips Hosp

Inside Limits

Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location)

5360 Cote Brillantie

Reside on Farm

Yes ☐ No ☐3. NAME OF DECEASED
(Type or print)

First

Middle

Last

Ada

Scales

4. DATE
OF
DEATH

Month

Day

Year

January

9

1963

5. SEX

Fem

6. COLOR OR RACE

Col

7. Married ☐ Never Married ☐Widowed ☒ Divorced ☐

8. DATE OF BIRTH

1 Jan 91

9. AGE (last birthday)

72

IF UNDER 1 YEAR

Months Days Hours Min.

9

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

RETIRED

11. BIRTHPLACE (City and state or country)

Nashville Tennessee

12. CITIZEN OF WHAT COUNTRY

U. S. A.

13a. FATHER'S NAME

Louis Scales

13b. MOTHER'S MAIDEN NAME

Mallissa

14. NAME OF HUSBAND OR WIFE

Dead

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of)

No

No

NO.

17. INFORMANT

Address

Mrs Cecilia Holley 7908 Thomas Brentwood

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Congestive Heart Failure;

Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

Arterio Sclerosis.

DUE TO (c)

450.0

INTERVAL BETWEEN
ONSET AND DEATHPART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal
disease condition given in PART I (a)PART III. If deceased was female was
there a pregnancy in last 90 days.☐ Yes ☒ No ☐ Unknown19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF
INJURYHour
a.m.
p.m.

Month, Day, Year

20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from

to

and last saw her alive on

Death occurred at

1054

m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE

1/14/63

23c. NAME OF CEMETERY OR CREMATORY

Washington Park

23d. LOCATION (City, town, or county)

St. Louis County Missouri

24. FUNERAL DIRECTOR

ADDRESS

Herman J. Smith

4247 W Labadie Ave

25. DATE RECD. BY LOCAL REG.

JAN 12 1963

26. REGISTRAR'S SIGNATURE

Earl Smith, M.D.

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS:

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

DATE AMENDED

VS 300
Rev. 4/59

1

2

3

4

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77

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Arthur L. Hilliard

Licensed Embalmer No.

4221

P. O. Address

3100 Easton Ave

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.